State of California Department of Consumer Affairs

BOARD OF BEHAVIORAL SCIENCES
400 R STREET, SUITE 3150, SACRAMENTO, CA 95814
TELEPHONE: (916) 445-4933 TDD: (916) 322-1700
WEBSITE ADDRESS: http://www.bbs.ca.gov

MARRIAGE, FAMILY, AND CHILD COUNSELOR EXPERIENCE VERIFICATION

Use a separate form for each person verifying hours of supervised experience for licensure as a marriage, family, and child counselor and for each employment setting. ***Exception:*** *If your primary supervisor was on vacation for a period of no more than 3 weeks, please have your interim supervisor also sign this form.* ***No erasures or corrections may be made. If any error has been made, complete a new form. Make certain that the form is complete and correct.*** *Experience verification forms are to be submitted by the applicant with his or her application for licensure.* ******* *The* ***address*** *you enter on this form is public information, and will be released to the public .*

BBS File #: _____ **Intern #:** _____

I. APPLICANT: (*Please type or print clearly in ink.*)

1. Name: _____
Last First Middle

*Address: _____
Number and Street City State Zip Code

Business Telephone: (_____) _____ Residence Telephone: (_____) _____

2. Workshops, seminars, training sessions, or conferences attended by applicant during the period of supervision.

Name and/or Course;# of sessions	Provider	Place Given	Date(s)	Total Hours

Use attachment if needed and have your supervisor sign the attachment.

II. SUPERVISOR: (*Please type or print clearly in ink.*)

1. Name of Applicant's Employer: _____ Telephone: (_____) _____
(Employment means the gaining of hours of experience in an allowable work setting as an employee or as a volunteer)
Address: _____
Number and Street City State Zip Code

2. Employment Setting:
a. Private practice ..... ☐
b. Governmental entity ..... ☐
c. Nonprofit and charitable corporation ..... ☐
(Attach copy of 501(c)(3) tax exempt letter from IRS)
d. School, College, or University ..... ☐
e. Licensed Health Facility as defined by Health and Safety Code Sections 1250, 1250.2, 1250.3, 1502, 1706.2, and 11834.02. ..... ☐
(Attach copy of their license)

3. Where did the applicant provide clinical services? _____

4. Were you, the supervisor, and the applicant both working within the same employment setting where the experience hours were obtained? ..... Yes ☐ No ☐
If No, please explain: _____
_____

II. SUPERVISOR: (*Continued*)

Applicant's Name: _____ BBS File Number: _____

5. As the supervisor I provided supervision during this time in the above employment setting on a:

- ☐ Self-employed basis in a private practice.
- ☐ Paid basis . . . . . Indicate by whom you were paid: _____
- ☐ Voluntary basis . . . . . Attach the original written agreement between you and the applicant's employer required by Title 16, California Code of Regulations Section 1833(b)(4).

6. Was the applicant during this time receiving pay for the employment? . . . . . Yes ☐ No ☐

- ♦ If Yes, attach a copy of the applicant's W-2 statement for each year experience is claimed. For the current year in which a W-2 has not been issued submit a copy of current paystub.

7. Dates the experience is being claimed: From _____ to _____
Mo Day Yr Mo Day Yr

8. Show only those hours of experience under your supervision within the scope of practice of a Marriage, Family, and Child Counselor. *Applicant's direct counseling with counselees*:

	Logged Hours
a. Individual counseling	
b. Couples, families, and children *(Min. 500 hrs.)*	
c. Group counseling *(Max. 500 hrs.)*	
d. Telephone counseling *(Max. 250 hrs.)*	
e. Administering and evaluating psychological tests of counselees, writing clinical reports and progress or process notes *(Max. 250 hrs.)*	

9. Supervisor's face-to-face supervision with applicant.

	Hours per week*	Logged Hours
a. Your individual supervision with applicant giving assessment and evaluation of experience .		
b. Your group supervision with applicant giving assessment and evaluation of experience. The group contained no more than _____ persons.		
c. How many weeks of supervised experience are being claimed?		

* Please explain/describe if hours vary greatly from week to week: _____

10. Describe the duties performed by the applicant under your supervision.

_____

_____

_____

11. SUPERVISOR:

_____ _____ _____ _____
Type of License | License Number | State of License | Date Originally Licensed

If M.D., were you certified in Psychiatry by the American Board of Psychiatry and Neurology during the entire period of supervision? Yes ☐ No ☐ Date Board Certified: _____ Daytime Telephone: (_____) _____

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

_____ _____ _____
Date | Print Name | Signature and Title

12. INTERIM SUPERVISOR:

_____ _____ _____ _____
Type of License | License Number | State of License | Date Originally Licensed

If M.D., were you certified in Psychiatry by the American Board of Psychiatry and Neurology during the entire period of supervision? Yes ☐ No ☐ Date Board Certified: _____ Daytime Telephone: (_____) _____

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

_____ _____ _____
Date | Print Name | Signature and Title